

**State of Iowa****Health Care Provider Biometric Screening Form****INSTRUCTIONS:**

- PARTICIPANT - complete section 1
- HEALTH CARE PROVIDER - complete section 2

Please fax completed form to Quest Diagnostics Health & Wellness Services at **(248) 864-4409****SECTION 1 - PARTICIPANT INFORMATION - Print clearly. If the form is illegible it will not be processed.**

Participant's Date of Birth (MM/DD/YYYY)		Gender	Unique ID#
<input type="text"/> / <input type="text"/> / <input type="text"/>		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
Participant's First Name		MI	Participant's Last Name
<input type="text"/>		<input type="text"/>	<input type="text"/>
Address			Unit/Apt
<input type="text"/>			<input type="text"/>
City			State
<input type="text"/>			<input type="text"/>
Email Address			Zip Code
<input type="text"/>			<input type="text"/>
Phone Number		Are you:	
<input type="text"/> - <input type="text"/> - <input type="text"/>		<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	

**Please read the following disclosure statement.** I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with my Employer; however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer-sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(Month)

(Day)

(Year)

**PATIENTS: Biometric Screening must be completed between January 1, 2016 and July 11, 2016. Results must be received by July 20, 2016** to receive completion credit or incentive (if applicable). This form must also be completed in its entirety, accurately and legible in order to be deemed complete, with services dates between 1/1/16 and 7/11/2016.

**SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS - For physician or office staff use only below this line.**FOR HEALTH CARE PROVIDER: **Client** is offering a voluntary wellness program to encourage participants to understand their health risk.

<b>Blood Panel</b>			<b>Fasting Status</b> (Check one)	<b>Blood Pressure</b>	
Total Cholesterol: <input type="text"/>	HDL: <input type="text"/>	TC/HDL Ratio: <input type="text"/>	<input type="checkbox"/> Fasting	<input type="text"/> Systolic	
Triglycerides: <input type="text"/>	LDL: <input type="text"/>	Glucose: <input type="text"/>	<input type="checkbox"/> Non-Fasting	<input type="text"/> Diastolic	
<b>Body Composition</b>			<b>Pulse</b>	<b>Tobacco Use</b>	<b>For Females Only:</b>
Height <input type="text"/> ft <input type="text"/> in	BMI <input type="text"/>	Waist <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	Currently Pregnant or Pregnant within the last 12 months
Weight <input type="text"/> lbs	Body Fat% <input type="text"/>	Hip <input type="text"/>		<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

☐

I certify the listed biometric values are correct

Facility Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Service/Test: \_\_\_\_\_

Health Care Provider's Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please fax completed form to Quest Diagnostics Health & Wellness Services at****(248) 864-4409 by Deadline 07/20/2016**

Date Faxed: \_\_\_\_\_

**NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid**